LOS ANGELES COUNTY
COMMISSION ON HIV HEALTH SERVICES

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COMMISSION MEETING

Minutes

May 8, 2003

Final

MEMBERS PRESENT	**MEMBERS PRESENT *(cont.)***	**OTHERS PRESENT**	**OAPP STAFF PRESENT**
Al Ballesteros, *Co-Chair*	Dana Pierce-Hedge	Robert Blue	Libby Boyce
Adrian Aguilar	Paul Scott/Richard Hamilton	James Boyd	Tim Carlson
Carla Bailey	Vanessa Talamantes	William Buycks	Ernesto Enriquez
Carrie Broadus	Kevin Van Vreede	Steven Clark	Robert Fish
Robert Butler	Tom West	Julie Coveney	Jane Nachazel
Genevieve Clavreul	Michael White Bear Claws	Bryan Garrity	Gabriel Rodriguez
Richard Corian	Rodolfo Zamudio	David Giugni	Rene Seidel
Richard Eastman	Fariba Younai	Mavra Gonzalez	Anna Soto
Whitney Engeran		John Griggs	Lynda Steele
Gunther Freehill	**MEMBERS ABSENT**	Miki Jackson	William Strain
Alexander Gonzales	Nettie DeAugustine, *Co-Chair*	Jennifer Karcher	Diana Vasquez
Marc Haupert	John Caranto	Maxine Liggins	
Charles Henry	Nancy Eugenio	Luis Lopez	
Howard Jacobs	Anna Long	Carol Maytum	
Rebecca Johnson-Heath	Mary Lucey	Jan Morrison	
Wilbert Jordan	Elizabeth Marte	Mark Parra	
Marcy Kaplan	Vicky Ortega	Walt Senterfitt	
Bradley Land/Dean Page	Alexis Rivera	S. D. Simon	
Mike Lewis		Doris Wahl	
Andrew Ma	**GUESTS ON THE AGENDA**	James Ward	
Edric Mendia	Dave Schwartz	Orenda Warren	
Hernan Molina	James Stewart	Kathy Watt	
John Palomo		Patricia Woody	
Chris Perry			

AGENDA ITEM	DISCUSSION	ACTION TAKEN
I. Call To Order	Mr. Ballesteros called the meeting to order at 9:30 a.m. Self-introductions were made.	
	Mr. Ballesteros announced that Tom West, City of West Hollywood, had been promoted to City Clerk, and would, as a result, be leaving the Commission. Mr. West introduced David Giugni who the City had nominated to represent the City. All present expressed appreciation for Mr. West's 13 years of Commission service.	
II. Agenda Order	Mr. Ballesteros asked for the Finance Committee report to be moved to after Public Comment. There were no other changes to the agenda. Later on in the meeting, the Financial Needs Assessment report was interrupted to present the OAPP report; the State report was moved up in the meeting and the Conditions of Award presentation was moved to the end of the agenda.	**MOTION #1:** Approval of the agenda with change as noted ***(Passed by consensus).***
III. Meeting Minutes	Ms. Broadus noted that her absence should be identified as excused. No other amendments were noted.	**MOTION #2:** Approval of April 10, 2003 minutes as amended ***(Passed by general consensus)***.
IV. Parliamentarian Training • Committee Limits on Debate	Mr. Stewart said he had done a training for Committee chairs a couple months previously. He noted that under normal parliamentary procedure, motions to limit debate in Committees were not allowed. The chairs felt, however, that was not useful for the Commission and had requested that he prepare a motion to allow such limits. His motion would permit motions to "allow the previous question" (which end debate) and motions to limit debate in all Committees.	
	Dr. Clavreul asked what time limitations would be set and who would set them. Mr. Stewart replied each Committee would vote for their own time limits (in total or per person) and when to enact them. Ms. Broadus asked who would determine when to stop debate and how it would be done. Mr. Stewart replied that "to move the previous question" stopped debate. A motion to limit debate either in total or per person could be done at the start of the meeting or anytime during the meeting. All such motions were determined by the Committee.	**MOTION #3:** Allow Committees to end or limit debate ***(Passed: 23 ayes, 1 opposed)***.
V. Public Comment	Mr. Buycks introduced himself. He was recently nominated as alternate to Richard Eastman for the Homeless Task Force seat. He noted that for almost 9 years, he had worked in HIV/AIDS client services on Skid Row and in assistance to the homeless. Mr. Eastman added that the Task Force had unanimously voted Mr. Buycks' nomination.	
VI. Standing Committee Reports • *Finance (moved up on agenda as revised)*	Mr. Ma introduced Commission consultant, Dave Schwartz, who is responsible for producing the Financial Needs Assessment. Its goal was to address Comprehensive Care Plan issues like funding gaps, current	

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⇨ *Financial Needs Assessment*	funding sources and potential sources of funding.	
	Mr. Schwartz called attention to the packet materials: a PowerPoint presentation, an Executive Summary and the full Final Report. He characterized the assessment as strategic. It was designed to begin a process for the Commission, OAPP and other stakeholders to view the relationship between CARE Act funding and other HIV health service funding. The present situation, goals, and obstacles were addressed, he said, from a systems point of view. The starting point was clients accessing a service, rather than individual providers.	
	The time period examined was Year 12, though there was some variation in fiscal year among funding sources. Title I Attachment Es were also compiled to review service provider funding. Fourteen EMAs around the country were queried to compare their Attachment Es to Los Angeles. Of those, Miami-Dade County, Portland, San Diego, San Francisco and Seattle-King County responded. Definitive answers were not possible due to the limited response. Los Angeles County staff was interviewed from OAPP and other areas of DHS, Mental Health, Children and Family Health, and the CAO. A financial needs assessment model was developed in Excel as an ongoing tool.	
	Mr. Schwartz said their preliminary estimate was that there is $650M from all sources for HIV/AIDS services in the County. Forty different funding sources and 21 service categories are detailed in the model.	
	Title I/II leverage within service areas was reviewed to identify areas where CARE Act funds are carrying an undue burden as funding of last resort. For example, it was noted that Legal Services and Permanency Planning are virtually 100% CARE Act-funded, while only about 15% of the primary health care core is funded through the Care Act, with the rest funded through other sources.	
	Title I/II funding ($96M) represented about 94% of CARE Act funding, with Title III, Title IV and Part F providing the other 4%. Of the estimated $646M in HIV/AIDS funding in the County, Title I/II represented 14% and all CARE Act funding ($103M) 16%. While, overall, this leverage appears good, the inconsistent leverage has implications for allocations to specific service categories. A new set of instructions and an electronic spreadsheet is being prepared to enhance consistency of the service providers' next Attachment Es. This will improve the ability to review funding according to the Comprehensive Care Plan's nine priorities and 21 service categories.	
	Of currently untapped or underutilized funding, the estimate ranged from 5% to 23% of the current $646M total or from $681M to $796M. That	

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	will include monies available to all service providers, including those not commonly thought of as part of the service provider network. The Veterans Administration, for example, is one of the largest HIV/AIDS service providers in the country. Four areas, he noted, appeared promising for additional funding.	
	The first priority identified is for increased governmental reimbursement. The MediCal system is a 50/50 Federal funding mix. It is estimated that 52% of PWHIV/A in the County are eligible for MediCal. For example, there is an estimate of $21,000 needed per PWA per year. The report estimated $10,500 needed per PWHIV per year. Using estimated populations from the Comprehensive Care Plan, as much as $175M could be available from MediCal if all eligible persons are enrolled. The Comprehensive Care Plan also identified 26% of PWHIV/A as eligible for Medicare that could yield an additional $59M. The numbers were estimated based on existing reimbursement rates.	
	Continuing with governmental reimbursement, MediCal Administrative Activities (MAA) provided funding to county departments and service providers in six areas: outreach, facilitation of MediCal applications, transportation of MediCal clients, program planning to increase capacity or improve service delivery, program compliance and claims submission, training of county and contractor staff. This capacity building could assist service providers to access all three MediCal funding areas: core services, optional services and MediCal waiver services.	
	MediCal Targeted Case Management (TCM) could be also be used for six purposes: assessment of client needs, preparation of individual service plans, implementation of service plans, client assistance to access services, crisis intervention, or planning and case plan review.	
	Transportation was identified as a critical need in the Comprehensive Care Plan, Mr. Schwartz said, but was allocated only about $1.6M Title I/II funds last year. To increase that, City of Los Angeles seniors and disabled are eligible for City Ride scrip that should be available for PWAs and, presumptively, PWHIVs. Seventy-two unit vouchers can be purchased quarterly for $15.34 or, if a person is on MediCal or SSI, for $6.34. Units can be used to purchase a Metro pass (12 units), Dial-A-Ride within the City (2 to 6 units), private lift vans (8 unit maximum) or taxis within the City (12 unit maximum). Metropolitan Transportation Authority (MTA) Disability Cards automatically qualifiy someone for scrip.	
	Dean Page asked what people needed to do to obtain scrip. Mr. Schwartz replied that Lynda Steele was exploring procedures. OAPP	

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	currently processed applications from service providers to facilitate the award of MTA Disability Cards. It was hoped a similar procedure could be set up for scrip.	
	In addition to cards and script, Federal regulations (especially the Americans with Disabilities Act or ADA) require transportation operators like MTA to provide disabled paratransit services (door to door) for anyone physically or emotionally incapable of using the fixed route system. He said Ms. Steele reported there had been past challenges with qualifying people. It would be necessary to collaborate with MTA to ensure a clear set of standards to simplify qualification.	
	A third area identified for potential new funds, he continued, was private insurance. Private insurance records, naturally, were not available for analysis to determine potential savings. In future, surveys could begin to capture better information. The Comprehensive Care Plan estimated that 13% of PWHIV/As had private insurance.	
	The final area identified for potential new funds was the increase of referrals to VA medical care. The assessment recommended Commission/VA collaboration to ensure consumer awareness of available services and service provider referrals of eligible clients to VA.	
	Mr. Schwartz then addressed challenges and barriers. Four focus groups representing 20 providers participated in identifying concerns. State and County budget shortfalls affected the availability of all funds. Fee-for-service programs were currently being evaluated by OAPP and the Auditor-Controller to assist in closing the gap, especially for substance abuse and residential care.	
	Focus group providers identified a need to diversify the mix of their own funding streams. Currently, he noted, about 20% of providers relied on three or fewer funding sources. Service providers as a group would also benefit by increased collaboration, for example, through joint grant applications, service center co-location or service delivery consortia.	
	In accordance with the Comprehensive Care Plan, there are three groups of barriers: structural, organizational (agencies) and service provider staffing patterns. A key structural barrier existed in meeting the needs of undocumented PWHIV/As. MediCal only reimburses for emergencies. An underserved group, and most probably growing, better data was needed and approaches defined to address the issue. Potential structural barriers included the proposed 15% MediCal cut as well as ADAP co-payments. LAHSA policy on McKinney cash matches has proved a challenge for some providers required to either put up funds in advance of the grant or increase matching funds over the grant life. An	

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	improved VA registration process and improved communication on client benefits is needed. Providers also requested access to capacity building funds for improvement implementation. MAA funds could assist in that area.	
	Organizational (agency) barriers include the infrastructure to apply for and manage larger grants. Improved systems to better determine MediCal eligibility are also needed. Providers requested easier access to information on potential funding sources through County departments other than DHS. Financial management training was also requested for both staff and provider board members.	
	Service provider staffing barriers emphasize staff expertise in third party reimbursement, grant writing assistance and quality management technical assistance.	
	The assessment provided recommendations on service provider communication, implications for the Year 13 Work Plan and internalization of the process. The assessment should be broadly disseminated to providers and the public electronically, via public meetings and possibly through the public awareness campaign. The Commission could champion capacity building for providers, especially in regards to training. Better communication with providers could also assist in addressing gaps, as more cost effective services reduce gaps that would otherwise need to be addressed with additional funding.	
	Turning to the Year 13 Work Plan, Mr. Schwartz noted this Financial Needs Assessment was originally scheduled for completion six to eight months ago in conjunction with the Comprehensive Care Plan. Since the original plan was now being revised, the Financial Needs Assessment was in a good position to provide feedback to the Priorities and Planning (P&P) Committee needs assessment process. The data from each could be used to refine the other. Additional areas of focus for P&P would be further evaluation of the needs of the undocumented and VA utilization by PLWHIV/A.	
	Eventually, all planning should be broken out, not only into the 21 service categories, but by SPA. Recruitment, Diversity and Bylaws (RD&B) interaction with the Consumer Advisory Boards could be of assistance in developing gap analysis.	
	It was recommended that the Joint Public Policy (JPP) Committee add specific tasks to their work plan to enhance communication with the City of Los Angeles and LACHAC/HOPWA.	
	The Finance Committee could work with service providers to improve accuracy of Attachment Es and to encourage broader use of the fee-for-	

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	service model. Collaboration could also be developed with DMH to learn their process of certifying service providers for MediCal.	
	Mr. West felt the document needed to be reviewed before a vote. Mr. Engeran asked how approving the Financial Needs Assessment would affect the Commission's work. Mr. Ma replied that the recommendations presented would be integrated into the work plan. Priority-setting would also be affected based on the recommendations. Mr. Jacobs noted that a timeline was included for recommendations. He felt co-chairs would need to go through the document and identify what they felt was important. While he applauded the Finance Committee's work, he felt it was not possible to evaluate it without more time to study it.	
	Mr. Engeran suggested the document be postponed for 30 days. Meanwhile, people could submit written questions to be addressed at the next meeting to ensure that discussion was productive.	
	Dr. Clavreul questioned why there were only 24 participants in the focus groups. She also felt it was not appropriate to vote on so large a document with so little time to review it. Mr. Schwartz replied that the document was designed to engender a strategic approach to Commission discussion of funding and service effectiveness. He noted that all Title I providers were invited to participate in the focus groups on any of the four dates, and that more than a third responded affirmatively and participated in the focus groups—which is a very health response.	
	Mr. Stewart commented that this was a planning document, not one that committed the Commission to take any action. As such, approval was more of a formality than not, as no commitments were being made.	
	Ms. Broadus suggested a paragraph be added to the Executive Summary defining the strategic planning process being used. While she acknowledged the document did not commit the Commission to anything, she also felt that such written documents often took on lives of their own once approved. She moved that the document be postponed 30 days. Each committee could review it and their co-chairs could offer feedback at the next Executive Committee for inclusion on the next Commission agenda. Mr. Land seconded the motion.	
	Michael Lewis reminded the Commission that this was a first attempt at this kind of assessment. As such, the document was unsculpted. The purpose was to estimate potential monies for HIV/AIDS and evaluate how well those monies were being accessed. There appeared to be about $200M in untapped funds available, he noted. He felt the message to the Finance Committee was to begin to actively seek access to those funds. The document contained unanswered questions. For	

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	example, he felt the case management offered by many service providers was not likely to be eligible for MediCal reimbursement. If it was eligible, other questions were raised about fee-for service. Even so, he felt it was important for the Finance Committee to expeditiously identify those potential monies most readily accessible, then determine what would be needed to go after the funds or to equip the contractors.	
	Ms. Broadus recognized this was a baseline document. She felt, though, that committees besides Finance should have the opportunity to contribute to the document, especially as recommendations affected the other committees as well.	
	Mr. Jacobs noted that the document was not identified as a "baseline" document, but as a "final report". It also estimated that about 25% of potential income was not being utilized, a notable assertion. He said that even as a member of the Finance Committee, he was not wholly comfortable with the document and felt it needed more review.	
	Mr. Vincent-Jones made a point of clarification on the motion. The Standards Of Care Committee would not be able to review it in one because they meet immediately following the Commission, and weren't notified in advance to put this item on their agenda for the May meeting (the one following this Commission meeting). If the Commission, he asserted, wanted to bring the document back for a vote and wanted all of the Committees to review it, it would need to be brought back to the July meeting.	
	Mr. Engeran asked if there were a timeliness issue: for example, was it needed for priority-setting? Mr. Haupert said the information was of the type needed for the Comprehensive Care Plan. He said due to the delay in getting the consultant to revise the plan, the Comprehensive Care Plan revision would begin in June or July. The information in the Financial Needs Assessment, however, could be taken into account in any case, so approval of the document would not delay their work.	
	Mr. Butler felt the emphasis should be on the initiation of the attempt to appreciate the big picture of the financial landscape. As such, understanding this was a first attempt, he was willing to vote for it. Ms. Broadus said she was willing to give a vote of confidence in terms of intent, but did not want to approve it without further review. Due to SOC's meeting schedule, Ms. Broadus' motion was amended to allow for 60-day review of the document.	**MOTION #4:** Postpone vote on Financial Needs Assessment for 60-day committee review ***(Passed: 21 ayes, 3 noes, 6 abstentions)***.
VII. OAPP Report	Mr. Henry noted that he would be attending Duane Bremond's funeral. Mr. Bremond was a founder and President of At The Beach, Shorey Incorporated, a provider of prevention services, health care access, self-	

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	esteem, social and economic development efforts in the African-American community. At The Beach has sponsored a Los Angeles Black Gay Pride Festival and created a scholarship fund recently renamed the Duane Bremond Scholarship Fund. Mr. Bremond had worked on the staff of Maxine Waters and the Nelson Mandela tour. He passed away May 1, 2003.	
	Mr. Henry acknowledged Dr. Robert Fish, OAPP's Director of Care Services, who would be leaving OAPP on May 15th to rejoin the County's Department of Mental Health (DMH), where he would return to direct patient care. Dr. Fish had been with OAPP four years. He joined OAPP as Director of Mental Health Services, then oversaw the merger of that division with Clinical Services into Care Services two years ago. He oversaw improvements in program monitoring, resulting in the current 100% monitoring of funded programs. He spearheaded the development of OAPP's viral resistance testing protocol to ensure best use of State vouchers and the laboratory results from them. He initiated the now annual training for care providers in each service category. All applauded Dr. Fish's contributions.	
	Mr. Henry then introduced Carol Maytum, HRSA Technical Assistance Consultant and one of the HRSA core consultant team. She was assigned to Los Angeles to assist in developing a unit cost reimbursement system for medical outpatient services. She would work with OAPP, providers and, as needed, with the Commission. She would also assist in the development of a full implementation plan, including training, standards of care and health outcome indicators, and development of the Requests For Proposals (RFPs).	
	The Title II award had been received, Mr. Henry continued. It reflected about a $144K increase. He acknowledged the State leadership of Michael Montgomery and Commissioner Dana Pierce-Hedge for maintaining flat funding for the local consortia, despite some decrease in California funding overall. He felt that was a courageous choice.	
• ADAP Report	Mr. Freehill reported on ADAP. Referring to a PowerPoint presentation, he noted that 50.5% of funding came from Title II, 36.5% from the State General Fund and 13% from drug company rebates required by statute. The current total of funding was $184.64M.	
	Title II was essentially allocated in two parts, a base grant and a Title II earmark, or ADAP set-aside. The base grant allocated about one-third of funds to drugs, diagnostic assays and medical monitoring. It also allocated funds to: the Minority AIDS Initiative, spent by the State primarily for outreach; consortia, funds allocated among the 58 California	

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	counties; Case Management Program, parallel to the MediCal Waiver Program, providing in-home services; CARE/HIPP, payment for private insurance premiums to deter public sector reliance; administration, planning and evaluation funds. The ADAP set-aside went primarily to drugs, with minimal amounts for diagnostic assays and medical monitoring. Overall, about 4 of 5 Title II dollars were used for medication purposes.	
	Mr. Freehill then presented a third quarter (2002-03) snapshot of ADAP-supported services. He noted that wholly accurate data was not available until the end of the year. There are 149 drug and drug combinations supported, with nearly 194K prescriptions for 19,500 people at a cost of $47.3M. If that much were spent each quarter, however, ADAP could not support it.	
	ADAP paid for several drug-related expenses: drugs, a drug dispensing fee to the pharmacist for each prescription, co-payments where needed to maintain private insurance and/or MediCal share of cost, enrollment fee, and diagnostic assays.	
	In terms of beneficiaries, the County served more Latinos and fewer Whites than California as a whole. Other groups and economic levels were similar between the County and State. Nearly 9,000 of the State's total 19,529 ADAP clients live in the County, with 297 served in Long Beach and 206 in Pasadena.	
	With 33.9% of living AIDS cases in the State, Los Angeles County accounts for 44.2% of ADAP beneficiaries and 50.5% of drug claim costs. There is no specific explanation for that, Mr. Freehill noted, though it could be conjectured that having the largest Latino population might also indicate a large number of people ineligible for MediCal.	
	ADAP beneficiaries may utilize ADAP alone; in conjunction with a third party, normally seen as using ADAP to pay MediCal share of cost; or to support private insurance. The County has significantly more people than the State relying solely on ADAP, fewer with private insurance and only half the State number using it for MediCal share of cost.	
	Strategies to address the State's budget crisis funding shortfall, Mr. Freehill went on, include ways to increase funds, decrease services and/or decrease clients.	
	Lowering the income threshold at which co-payments are imposed can be used to increase funds. Drug prices also might be better negotiated, particularly since California pays for more drugs on the ADAP formulary than for those on the MediCal formulary. While the price disparity has been decreased over time, it remains. It might also be possible to increase drug rebates from pharmaceutical companies.	

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	It might be possible to increase the Federal allocation to ADAP. Two programs were initiated in the last reauthorization to support drugs in states with the greatest need. California is unlikely to receive such funds due to its traditionally robust ADAP. A shift of funds among Title II programs would be more likely. The State could also increase General Fund contributions to ADAP, but the current budget makes that difficult.	
	Mr. Butler noted that Medicare reductions by Congress had prompted HMOs to increase co-payments. Many consumers in his constituency lost coverage that way and were forced onto ADAP. He wondered if that problem had been studied. Mr. Freehill responded that it had not been specifically. However, the CARE/HIPP program was targeted to help people pay insurance premiums. He noted it was cost-effective, since people could retain full medical care through their provider. The numbers of people accessing that program have been growing, he added. Mr. Ballesteros said the drugs were just too expensive. He recommended advocacy to lower prices.	
	Mr. Freehill discussed another way to lower the cost of ADAP – by reducing services. He noted, however, that 50% of ADAP costs were from 5 (LAC) or 6 (CA) drugs. Eleven drugs accounted for 75% of costs and 90% of costs were from 26 (LAC) or 25 (CA) drugs. While some drugs could be removed from ADAP without serious harm, potential savings were minimal until significant cuts were posited. In addition, 81.7% of costs were for 18 anti-retrovirals. While there are about two dozen drug classes reported on by the State, more than 4 out of 5 dollars being spent are on anti-retrovirals.	
	Saving funds by reducing clients was being done in several states, Mr. Freehill continued. Some states had suspended new enrollments. Ten states had waiting lists. There was some sentiment for California to establish a waiting list and some in favor of triaging clients so that only those most ill would receive services. He said it was important to be aware of proposals being made.	
	The Governor's budget proposal is routinely released for discussion in January. After the Governor has the opportunity to incorporate feedback, the May Revise is released. Often groups are unwilling to give up points before the May Revise in anticipation of renewed negotiation at that time. The State Constitution requires that the Governor sign a budget by June 30th, though that deadline is commonly missed. Mr. Freehill commented that the California Governor has "blueline authority" which allows him to eliminate or make changes to items he dislikes even after a budget has been passed.	

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	At the time of the presentation, the current Governor's proposal included co-payments starting at $30 per prescription per month for those at 200% of the Federal Poverty Level (FPL), $45 at 300% FPL and $50 at 400% FPL, each client's total monthly cost depending on his/her co-payment and the number of prescriptions filled. Total savings were expected to be $7.2M. This proposal would vary from services like Medi-Cal that capped monthly expenditures. Mr. Engeran commented that the $7.2M projected savings would not fill the $66.37M funding gap between the ADAP grant and expenditures. Mr. Freehill responded that it was not expected to fill the entire gap, but to generate some savings.	
	Ms. Broadus said the fixed MediCal fee appeared to support the Financial Needs Assessment goal of increasing MediCal enrollment. She asked how MediCal addressed drugs. Mr. Freehill said MediCal tested both income and assets. A fixed fee may be required per month for all services, including drugs, depending on the client's financial assessment. Mr. Land said the cost could range up to $1,000 per month. He noted that ADAP discounts no longer applied when a drug moved to MediCal. His experience with consumers was that the fee absorbed 60-70% of income and drained resources.	
	The number of drugs supported could also be reduced, Mr. Freehill continued. However, since anti-retrovirals were the key class of drug covered, there would be a limited fiscal impact if those were spared. If they were not spared, their costs would tend to shift to other Title I/II funding, resulting in impacts elsewhere. Supportive services, like viral diagnostic assays, might also be reduced. However, such services supported the most cost effective drug utilization so that curtailing them would also tend to result in cost shifts to other funding sources.	
	Mr. Freehill summarized that ADAP pressures were deep and growing. With greater success in medical treatment, more people were living with the virus and more became ADAP beneficiaries. Meanwhile, drugs available to treat HIV continued to increase, as did their cost. These pressures, he concluded, had no easy answers.	
	Mr. Haupert noted that often there were accusations of fraud and/or waste in governmental programs. He asked if there had been any indication of them in ADAP. Mr. Freehill replied that he was unaware of any. ADAP had been extensively reviewed nationwide, during the last reauthorization, though he did not believe California was reviewed.	
	Dr. Jordan asked what Canadians paid for the drugs. Mr. Freehill replied they cost much less there. Dr. Jordan suggested we might be able to purchase drugs through the same system they do. Dr. Jordan also	

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	stated it was important to have a County safety net, not only for those who might fall through the system later on, but for those already falling through. He pointed out, for example, that he could not treat an HIV+ patient co-infected with Hepatitus C unless he/she was on MediCal. Mr. Freehill replied that budget discussions were aggressive. For that reason, it was important not to indicate that one was willing to accept expenses for a service before the budget was signed. Such an indication would cause service to lose support in the budget process.	
• Conditions Of Award (COA) Year 13	Mr. Vincent-Jones noted that the Title I Award included Conditions Of Award (COAs). COAs were HRSA requirements of grantees and administrative mechanisms to ensure appropriate, on-going implementation of planning and service practices mandated by legislation. COAs must be met during the course of the grant cycle. This presentation was an update on current COAs, he said.	
	Points are assigned to each COA. They are earned when the COA has been satisfactorily fulfilled by the due date imposed. One quarter (26 of 100 points) of the Supplemental, competitive, part of the application are earned by meeting the COAs. For comparison, the total award this year was close to $40M, with $18.5M in Supplementary funds. Consequently, each point is worth approximately $200K. As grant amounts increase, so does the worth of each point, he commented.	
	The Notice of Award is normatively accompanied by the list of COAs that are due over the next six months. Mr. Vincent-Jones reported that this year's COAs were comparatively easy, with no new ones imposed and some previous ones not re-imposed. He felt confident that all 26 points could be earned this year.	
	COA A.2, budget revisions consistent with the final award, had already been submitted, he said. It included narrative justifications for Planning Council Support, Administrative Agency, Quality Management and Program Support. Last year a complete packet describing Quality Management was required, but that was not needed this year. The Planning Council Support portion was distributed in the Commission packet, he added. He reported that the Project Officer, Jo Messore, had told him the COA had been met and would be lifted shortly. It was worth 3 points last year.	
	COA B, membership reflectiveness, was a letter from the Commission assuring compliance with the 33% non-affiliated consumer membership mandate and assuring that consumer membership accurately reflected the epidemic 's demographics in the EMA. Mr. Vincent-Jones noted one point was lost last year because reflectiveness was not met by the April	

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	deadline. It was met by September, however, earning 1 of the 2 points available. This COA had already been removed, he said. He added that one table, detailing skills and experience, was no longer required.	
	COA B.1, FY 2002 Financial Status Report (FSR), is to ensure full expenditure of Title I funds. While due May 31st, extensions were permitted through September 30th. The extension is used each year as it is not possible to close the books in time for the earlier date. Points are earned or lost depending on the degree to which the prior year's budget was expend-ed. That had never been a problem in Los Angeles County, he noted. The COA is usually worth 7 points.	
	COA B.2, CARE Act Data Report (CADR), is used by HRSA to track epidemiological and demographic disease trends. Mr. Vincent-Jones noted that providers would be familiar with provider and client-level data submission requirements to OAPP. This information was then submitted to HRSA. While there are no points attached, submission is required. The material had already been sent in, he added.	
	COA B.3, FY 2002 Annual (Final) Progress Report, is a report on the prior year with a narrative and several forms. Last year's Commission Grievance procedures and Bylaw revisions had to be submitted for this COA. This year, less is required, including: a Table 9 showing fund allocation; and a report on program implementation with indicators on increasing access to care, maintaining clients in care, reducing/eliminating disparities, improving quality and insuring fiscal accountability. As in previous years, ten challenges must be identified along with what was being done to overcome them. A Certification of Aggregate Administrative Costs must be submitted. It verifies that the EMA is not spending more than 10% of funding on administrative costs. Progress and challenges in implementing HIPAA requirements are new to the report this year. He suggested SOC or another committee plan to incorporate HIPAA training into the Commission training. While due May 31st, an extension is available through September 30th. Normally the extension is used and this condition is submitted with the FSR. Last year 2 points were awarded for this COA.	
	COA B.4, audit of grantee mechanism, is the annual County audit, he said. While no points are attached, it is required.	
	COA C.1-5, priorities and allocations, focuses on ensuring that funds have been and are being spent by the administrative agency (OAPP) according to the Commission's allocations. The different items pertain to what was spent last year, current spending plans and a follow-up at the end of the year. C.3 is a letter of endorsement from the Commission	

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	Co-Chairs. The FY 2002 allocation table has been submitted. C.2-4 are due June 16th, he noted. Three points were available for this last year.	
	At the time of this presentation**, COA D.1-4**, provider budget packages, were the most laborious COAs and were designed to ensure all funds were obligated and were used as funding of last resort. A variety of financial information was required concerning providers and their contracts, including: a consolidated list of contracts, Contract Review Certifications (CRCs) certifying funds contracted to each provider, budgets and narrative justifications for each contract, and a summary of other funding from each provider (Attachment E). OAPP would be revising Attachment E as discussed earlier. Usually 1,500-2,000 pages, this major COA was due July 31st and worth, in past years, 4 points.	
	COA F.3, E.1-3, Minority AIDS Initiative, requires a plan, an interim progress report and a report at the close of the year. Both expenditure of funds and outcomes are required, Mr. Vincent-Jones said. Reports were due throughout the year, totaling 3 points.	
	COA G (FY 2002), F.1 (FY 2003), Women, Infants, Children and Youth (WICY), verify that expenditures for these groups are in proportion to their prevalence in the population of PLWA in the EMA and in the client population. This COA was initiated two years ago, and this is the first year that the EMAs are expected to report on each group separately. Due in July, this COA was worth 2 points last year.	
	COA G, Local Pharmacy Assistance, requires a summary of the EMA's drug acquisition plan, formulary and description of cost savings for pharmaceuticals purchased with Title I funds, if the EMA uses its funding for that purpose. A new COA last year, it could turn out to play a pivotal role in the EMA's service delivery, if – as has been discussed by some -- the Commission chooses to use funds to offset ADAP co-payments or otherwise provide drugs. While some limited medical outpatient funds are currently used for that purpose, such an endeavor would require some major policy and procedure development. The COA was worth 2 points last year.	
	COA H, special conditions, are typically used by HRSA to correct deficiencies. Points are deducted from the final score if this form of COA is not satisfactorily completed. No special conditions have been assigned to Los Angeles County in 2 ½ years, and the last special condition COA regarded open nominations. HRSA considered a special condition this year due to concern over the length of time it takes to fill vacant staff positions, both on the Commission and at the administrative agency, especially in quality management. They chose not to impose one based	

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	on the staffing pattern moving forward and most quality management positions having finally being filled. Instead, Ms. Messore spent much of her visit meeting decision-makers in the staffing process to emphasize its importance.	
VIII.State Office of AIDS Report	Ms. Pierce-Hedge said that when the State received its Title II funding, they did have some funds to move around in the ADAP supplement. They chose to hold harmless Title II community-based care programs.	
	She said the trailer bill was moving forward, but they had not seen the language. ADAP co-payment language had come out of the Department of Finance, she noted, not DHS. The proposal would heavily impact about 24% of ADAP clients. She had also seen public discussion on implementing a waiting list. Legislation would be required to implement any such proposal.	
	She noted that about three years ago a study was done to evaluate cost savings through formulary reduction. Only about $12M of the entire budget was spent on drugs other than anti-retrovirals or drugs that assist clients in coping with anti-retroviral side effects. She concurred with Mr. Freehill's presentation on the core nature of drugs supported by ADAP.	
	New drugs are another issue, she said. Fuzeon costs about $22K per year. Not only was it a salvage therapy for those whose treatment is failing, but some populations tend to present later in the course of the disease and require more intensive treatment. The Medical Advisory Committee is currently looking at criteria to start Fuzeon. For the first time, the Committee is also developing stop criteria for when it is not being useful. There had been thought, as well, on how the formulary might be shifted to absorb the cost. Other states are addressing these same questions, too, she said.	
	Ms. Pierce-Hedge said that the AIDS directors of several larger states met about a month ago in Washington, D.C. to negotiate with the pharmaceutical companies. Some additional rebates were negotiated. Currently, 13% of the drug formulary is paid for by rebates. However, when drug prices are reduced, rebates are reduced. The State Office of AIDS also has an obligation to the Department of Finance (the Governor's financial arm) to generate a certain amount of rebate funds.	
	All ADAP programs would be meeting the following week in Washington, DC. Issues discussed earlier would be addressed at the meeting. She noted there are difficulties when all the states meet together, because there are notable disparities among them. Some have only 6 drugs on their formularies, for example, while others have more than 200 people on a waiting list. Consequently, the conference was planned with	

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	different tracks for different groups of states.	
	Ms. Pierce-Hedge pointed out that they are receiving about 2,000 new clients per year. The cost of drugs has also escalated. The combination resulted in the shortfall.	
	She said that it is important for the Commission and others to actively defend the ADAP program. Her office has also begun work on similar issues that pertain to reauthorization. She felt interested parties should get an early start on reauthorization issues. With the dire needs of southeastern states, she noted, it required extra work to defend the resources of larger states.	
	Support is also needed to maintain resistance testing. While it supports the most cost effective use of drugs, some had been looking for dollars in that program.	
	Mr. Jacobs asked what she might have heard about effectiveness of recent lobbying, especially on the co-payment issue. She replied that she was aware of various lobbying efforts, including others such as block-granting education and primary care dollars, but had heard nothing specific about any of them.	
	Mr. Ma asked if alternatives to co-payments are being discussed. She said there had been discussions about waiting lists and reducing resistance testing. She noted that the Office of AIDS has not been involved in the discussions about co-payments. A certain amount of cost savings was defined first and the co-payments were derived from that.	
	Mr. Engeran asked for an update on correspondence between the State Office of AIDS and OAPP on the State funding formula. She replied that she had responded at the Commission twice. They would be looking at the entire area as data improved. CHPG had merged prevention with health. Discussions were beginning to be held with its allocation group. She said the next meeting with the group was scheduled for August.	
	Dr. Jordan commented that Oasis Clinic had surveyed their patients who would be required to make a co-payment. He said 98% of the patients responded that they would not be able to take their medications routinely if a co-payment were required. He said the Medical Association and others should raise their voices because co-payments would destroy the system. Patients would take their medications for a few months or sporadically, leading to resistance. Then both patients and cost savings would be lost. He said he would prefer a waiting list to co-payments as, at least, it would not increase resistance.	
	Ms. Broadus commented that information in the Financial Needs	

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	Assessment Attachment E breakdown of agency funding sources indicated significant MediCal funding. She encouraged looking at ways to increase drug coverage from sources other than ADAP, rather than looking at ADAP in isolation. She also felt it was important to look at the total service environment rather than one aspect of it.	
	Mr. Ballesteros asked if a policy letter on ADAP had been prepared for review. Mr. Molina replied that it had been. Mr. Ballesteros asked about the May Revise budget. Mr. Molina replied that the Governor should present the blueprint on May 14th. The California League of Cities would meet in Sacramento to evaluate effects on their cities. Mr. Molina would be attending. The Governor, Senate and Assembly would all be accepting input on the budget, though time to present input was limited.	
IX. Select Committee on Prevention Planning Report	Mr. Mendia reported the PPC continued to work on the PPC 2004-2008 Prevention Plan. Progress had been hampered by the Department of Health Services delaying approval in key areas of support.	
	The summit scheduled for May1-2 was not approved and had to be cancelled. Work planned for the retreat was being rescheduled for regular, and perhaps special, meetings. Approval for the independent contractor to assist with needs assessment, gaps analysis and writing was also delayed. The PPC unanimously approved a letter asking DHS to expedite approval of the process to identify the contractor and approval was received April 22nd. The PPC is moving ahead with the process, albeit behind schedule. The summit issue had also been agendized at the following Health Deputy meeting; it was hoped that it still might be held.	
	He noted that the third nominated representative to the Commission, Kellii Tombacco, was being replaced by Kathy Watt, Director, Van Ness Recovery.	
	He called attention to the recent CDC prevention initiative in the packet. It placed special emphasis on testing and prevention for positives, as well as identification of perinatal HIV. The plan would need to be responsive to the new initiative and its funding implications, he noted.	
	Ms. Talamantes added that the PPC was moving forward with the Task Force recommendations and working on the action plan developed by the Joint Public Policy (JPP) Committee. The PPC and Commission co-chairs would meet the next day. Representatives of both bodies would make presentations at both June meetings. The bodies would then develop responses that would be incorporated into votes on recommendations.	
X. Recess	Recess was taken earlier in the meeting.	
XI. Co-Chairs' Report	Mr. Ballesteros reported that work continued on the separation. The	

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• Commission Separation	target date remained July 1st. Work on the staffing pattern continued. He acknowledge Charlene Abe, from the Board of Supervisors Executive Office, was their designee to spearhead the process.	
	Ms. Kaplan asked Ms. Abe if, considering it was already May 8th, it was realistic to expect the work would be accomplished by July 1st. Ms. Abe replied that people would not be in place by then, but that it was anticipated the positions would be allocated.	
	Mr. Butler asked if items could be filled fairly soon, for example, 30 to 45 days after items allocation. Ms. Abe said that would be optimistic. The Board would be meeting at the end of June to adopt a budget. Her plan was to have both budget and staffing pattern included so they could be adopted at that time. Once adopted, the Department of Human Resources would need to allocate the appropriate levels of positions. Recruiting and hiring could then proceed.	
	Mr. Engeran asked how the Commission could ensure that candidates being considered were appropriate in reflecting the needs of the Commission both in skill levels and sensitivity. Ms. Abe replied there were several ways of holding an exam. She assumed the Commission Co-Chairs would want to participate in an interview selection panel. Mr. Ballesteros noted there were also job descriptions and classifications.	
XII. Standing Committee Reports • *Finance* ⇨ *Financial Needs Assessment*	Finance was reported on earlier in the meeting.	
• *Priorities and Planning*	Mr. Haupert noted that the Committee work plan was moving forward, though there was some delay in securing the contractor to assist with the Comprehensive Care Plan update. They were doing some preliminary work, for example, incorporating the Financial Needs Assessment.	
	He said the P&P was collaborating with the SOC on the Patient Bill of Rights. SOC would finalize language that would go into the Comprehensive Care Plan.	
	A specific format was being developed to assist the Commission in communicating new priorities, allocations and directives to OAPP and planning partners. The device would ensure there was no lack of clarity of Commission intent when it turned over a subject to OAPP for the RFP and contractor process.	
• *Recruitment, Diversity and Bylaws* ⇨ *Slate of Candidates*	Mr. Butler asked the Commission to approve the nomination of Ruth Davis, candidate for the MediCal seat, and move it forward to the Board of Supervisors. Mr. Land noted that Ms. Davis' application indicated she	**MOTION #5**: Recommend Ruth Davis to the Board Of Supervisors for the Commission MediCal seat

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	had only treated three AIDS patients. Ms. Broadus asked if we were not primarily seeking someone with MediCal experience, particularly in light of the need to improve use of MediCal-funded care. Mr. Butler said she also had the responsibility, as a representative of MediCal, to review PWHIV/A medical records for MediCal. She was the person, he added, recommended by the MediCal office.	***(Passed: 21 ayes, 1 no, 5 abstentions).*** **MOTION #6**: Extend meeting by 10 minutes ***(Passed by Consensus).***
⇨ *Open Nominations Process*	Mr. Butler reported that the Open Nominations process was continuing and applications were being accepted. He noted that Commissioners terming out needed to re-apply for their seat if they wished to stay. He called attention to the Commission roster in the packet and asked members to compare the roster with their "gold letter" from the Board Of Supervisors so that inaccuracies could be corrected. Mr. Gonzales said information should be given to Mr. Butler or himself with a copy to Mr. Vincent-Jones or Jane Nachazel.	
	Ms. Broadus asked who was responsible for the Form 700s and what effect tardy submission had on Commission membership for those listed. Mr. Vincent-Jones replied the information was from the Executive Office of the BOS. He noted staff had found some inaccuracies and requested Commissioners report errors to staff. He said Commissioners could be fined starting at $100 and increasing over time.	
• *Standards Of Care*	Dr. Jordan reported that Fariba Younai had been elected co-chair of the Committee. Mr. Engeran asked if there were a timeline on the Bill of Rights. Dr. Jordan responded that he would know more after their next meeting.	
• *Joint Public Policy* ⇨ *Homeless Proposals*	Ms. Broadus noted that the co-chair was not in attendance. She reported there had been agreement that a letter should be sent to the BOS about strategies to increase revenue. She was not certain as to the status of the letter, but said that it was to speak to more than one HIV/AIDS service.	
	Mr. Eastman asked about the letter he had requested supporting the proposal of a year-round homeless center. The Executive Committee had referred it to the Joint Public Policy Committee. Ms. Broadus said it hadn't been discussed as of yet. Mr. Eastman said it was important that the subject be moved quickly. Ms. Broadus requested Mr. Eastman provide background information on the subject to the JPP. Mr. Engeran noted that the JPP had not met since the Executive meeting. He invited Mr. Eastman to the meeting May 16th.	
XII. Announcements	Mr. Eastman said the Medical Marijauna Task Force meeting was scheduled for August 2nd, 2003 at the Hollywood Ramada Hotel. It would be co-sponsored by Assemblyman Paul Koretz.	

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	Mr. Perry reported the next Advocacy Academy would be Saturday, June 7th on the Queen Mary in Long Beach from 9:30 to 4:30. He said Being Alive LA, Being Alive Long Beach and Positive Images were co-sponsoring a client-level social, Spring Fling, Saturday, May 31st at the Village. There would be a screening of a new documentary film, Damaged Goods, and a presentation by Mark Glands.	
	Mr. Page said there would be a consumer advocacy meeting the next day at ASC at 10 a.m. He also announced that Prototypes had nine beds available for PWHIV/A who have substance abuse problems. Mr. Page said that he had some posters for the Candlelight Memorial. The theme this year would be "Remembering the Cause: Renewing Our Commitment". Flyers for all events were available on the table. He noted that he hoped to have some positive information about the food issue by the next meeting.	
	Mr. Hamilton announced the First Annual Teddy Bear Picnic May 31st at Wilson Park in Torrance. It was co-sponsored by Minority AIDS Project, Being Alive South Bay, ReadyMeds, AIDS Food Store. Flyers were available on the table.	
	Mr. Mendia announced that Whittier Rio Hondo AIDS Project had an opening for a full-time case manager.	
	Mr. Lewis suggested an appropriate recognition of Mr. West's many years of service. Mr. Ballesteros concurred.	
XIII. Adjournment	The meeting was adjourned at 1:30 p.m. in memory of Duane Bremond who died May 1st. Ms. Broadus recalled his many years of leadership in the community, reaching out to African-American churches as early as the mid-1980s. Ms. Broadus personally expressed gratitude for Mr. Bremond as her mentor. Mr. Ballesteros adjourned the meeting with a moment of silence for Mr. Bremond.	

AGENDA ITEM	DISCUSSION	ACTION TAKEN

MOTION AND VOTING SUMMARY		
MOTION #1: Approve Agenda.	***Consensus***	**Motion passes**
MOTION #2: Approve March 13, 2003 Minutes.	***Consensus***	**Motion passes**
MOTION #3: Allow committees to end or limit debate.	**Ayes:** *Aguilar, Bailey, Ballesteros, Broadus, Butler, Corian, Eastman, Engeran, Haupert, Jacobs, Land, Ma, Mendia, Molina, Palomo, Pierce-Hedge, Scott, Talamantes, Van Vreede, West, White Bear Claws, Younai, Zamudio*; **Opposed:** *Clavreul*; **Absentions:** *none*	**Motion passes:** *23 ayes, 1 opposed, 0 abstentions*
MOTION #4: Postpone vote on Financial Needs Assessment to the July Commission meeting to allow for 60-day committee review and report to Executive Committee.	**Ayes:** *Aguilar, Bailey, Broadus, Butler, Clavreul, Eastman, Engeran, Gonzales, Hamilton, Haupert, Jacobs, Johnson-Heath, Kaplan, Land, Mendia, Molina, Perry, Talamantes, Van Vreede, West, Zamudio;* **Opposed:** *Corian; Lewis, Palomo;* **Absentions:** *Ballesteros, Jordan, Ma, Pierce-Hedge, White Bear Claws, Younai*	**Motion passes:** *21 ayes, 3 opposed, 6 abstentions*
MOTION #5: Recommend Ruth Davis to the Board Of Supervisors for the Commission MediCal seat.	**Ayes:** *Bailey, Ballesteros, Broadus, Butler, Corian, Eastman, Engeran, Gonzales, Hamilton, Johnson-Heath, Jordan, Kaplan, Lewis, Ma, Mendai, Palomo, Talamantes, VanVreede, West, White Bear Claws, Younai;* **Opposed:** *Jacobs*; **Abstentions:** *Aguilar, Clavreul, Haupert, Land, Perry*	**Motion passes:** *17 ayes, 0 opposed, 3 abstentions*
MOTION #6: Extend meeting by 10 minutes.	***Consensus***	**Motion passes**